The Hampden Hippocrat

A Bulletin for the Hampden District of the Massachusetts Medical Society

VOLUME XXII JANUARY, 1966 NO. 1

PUBLIC LAW 89-97
("MEDICARE")

Hampden District Medical Society

1414 STATE STREET — SPRINGFIELD, MASS.

Telephone: REpublic 6-0661

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The Hampden Hippocrat

"Life is short and art is long, the occasion fleeting, experience fallacious and judgment difficult."
Hippocrates

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"MEDICARE" AND YOU

by JAMES Z. APPEL, M.D., PRESIDENT, A.M.A.

(An address presented at the H.D.M.S. Meeting of December 7, 1965)

I appreciate this opportunity to discuss with you the new "Medicare" law which has been described as the biggest social welfare measure in history. Big it is! It will touch the lives and paychecks of virtually every American. It will bring about profound changes in the relationship between millions of older Americans and the sources of health care - their physicians and hospitals. It will cost 4½ billion dollars a year to start. It will require the services of from 7,000 to 8,000 new federal employees to administer its provisions. It will result in steadily rising Social Security taxes between now and at least 1987 to finance its benefits. It will bring a great new influx of patients into the nation's health facilities and place increased demands on the time and

NEXT DISTRICT MEETING, FEB. 1 (See Page 9)

energies of physicians across the country. Most significant of all, it will usher in a new era of Federal government participation in a certain aspect of the national life in which it has never been involved before.

Organized Medicine's Position

In the company of a great many others, the medical profession opposed the principle of Social Security financing of the health care of a large segment of the population without regard to the needs of individuals for financial aid. We thought it was wrong for the young taxpayer struggling to make a home for a growing family to be required to pay the medical expenses of a retired millionaire. Nor did it seem reasonable for a younger person to pay heavy taxes for 40 or more years without assurance that he would ever realize benefits comparable to the payments made or even any benefits whatsoever. Unless he lives past age 65, he will receive no benefits for that portion of his Social Security tax that is ear-marked for "Medicare." Beyond all this, for we are first and last physicians, our major concern was that the adoption of the program would retard, rather than promote, the science and art of medicine and the betterment of the public health.

However, the long debate is over, Congress has made a fundamental policy decision. It has extended Social Security to cover hospital care for the nation's elderly. At the same time, it has offered to everyone over 65 a government program to help them meet medical expenses, with premiums to be shared by individuals and the Treasury. It has extended the Kerr-Mills Law to cover hospital and medical care of the financially needy of all ages.

"Foot in the Door"

This action, as it now stands on the statute books, is what occupies us today, and we dare not take it lightly. "Medicare" is the biggest invasion by the Federal Government into health care of all the existing programs, for it affects almost 20 million Americans. Moreover, it also is a program that has the greatest danger of expanding itself to cover the entire population and thus become a national system of health care.

Some may say: "Oh, you're crying 'wolf' again!" Am I? On October 20, 1965, the ADA (Americans for Democratic Action) indicated that its 1966 legislative program might include a government supported health insurance plan for anyone who wants it. In the Oct. 25, 1965, issue of "The A.M.A.

(Continued on Page 19)

Cover: Representing the three levels of organized medicine at the meeting of H.D.M.S., Dec. 7, 1965; (left to right) Claude E. Welch, M.D., President, M.M.S.; (in the absence of Henry Burkhardt, M.D., President) Donald R. Hayes, M.D., Vice President and President-Elect, H.D.M.S.; James Z. Appel, M.D., President A.M.A.

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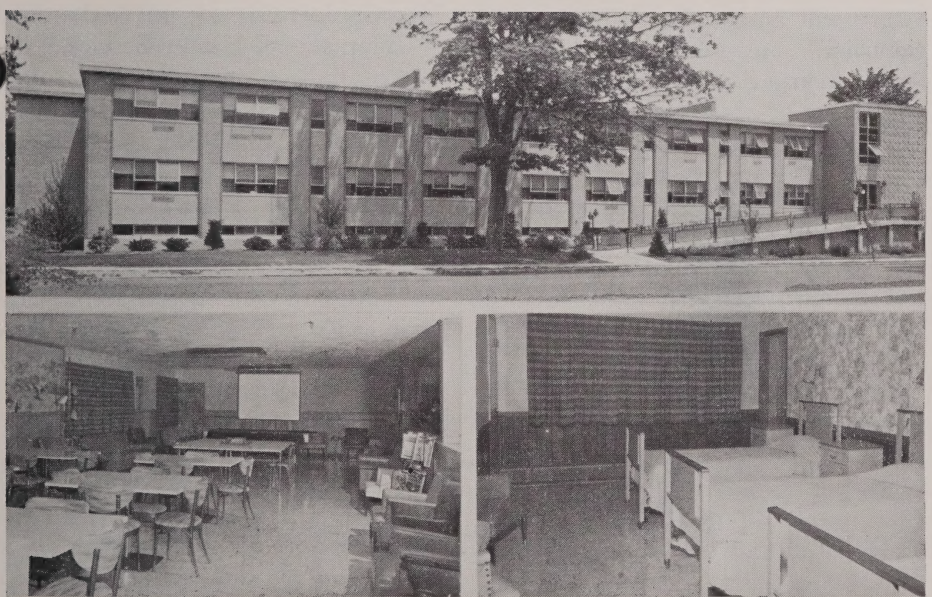

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EXECUTIVE COMMITTEE
(Highlights)

The regular monthly meeting of the Executive Committee was held on December 21, 1965, at the H.D.M.S. meeting room. The meeting was called to order at 8:03 P.M. by President Burkhardt. Present were: Drs. Memery, Nero, Griffin, Mahoney, Miner, Hayes, LaMarche, Mozden, Moore and Mrs. Purdy.

Minutes of the November meeting were read and approved as read by the committee.

Letters

A request from Dr. Claude Welch, President of the M.M.S., was read on utilization programming. This was discussed by the committee and the Secretary will answer Dr. Welch's questionnaire.

Dr. Alonzo Sheffield has been granted a leave of absence from the H.D.-M.S. while taking a residency in gastroenterology in New York City.

Mrs. Purdy gave a report of the office for the past month. The following committees have met during the last month: Mental Health, Medico-Legal, Disaster Medical Care, Censors, and Medical Advisory.

There was no new business so the Executive Committee adjourned and the Grievance Committee convened.

Three grievances were heard and letters will be sent by the Secretary.

The meeting adjourned at 9:40 P.M.

AUXILIARY EVENTS
Luncheon Meeting

A luncheon meeting at Shaker Farms Country Club on October 26th, opened the current season of the Woman's Auxiliary. It was gratifying to the new officers and board to have so many members turn out to get the season off to a good start. After a delicious luncheon, a business meeting was conducted by Mrs. Raymond Conway, president. Two changes in the board were announced: Mrs. William Mosig is the new scholarship treasurer and Mrs. Gardner Cox, II, will be chairman of International Health Service.

The Longmeadow Theatre-on-the-Green, under the direction of Mrs. Mary Pease, presented the first act of "Two for the Seesaw", a popular Broadway play. Flora Marie Cowles and Richard Dorshimar gave excellent characterizations and the play was most enjoyable. Mrs. Jacob Shammash had charge of the program. Mrs. Edward Natham was luncheon chairman, Mrs. Bernard Tillman, co-chairman.

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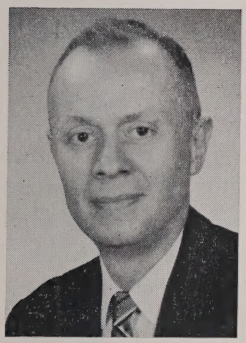
President's Page



YOUR SHARE

The Social Security Amendments of 1965, which gave us "Medicare", also included self-employed physicians in the Social Security System. Aside from benefitting from "Medicare" in our old age, we may now be eligible for monthly retirement benefits as early as age 62 or monthly survivors' benefits (if we don't make it to 62) for our widow and/or any unmarried child under 18 years old, or a monthly disability benefit if disabled before the age of 62.

To be eligible to receive benefits, one must have social security credits for a certain amount of work. You can receive 1 credit for each 3 months — calendar quarter in which you are paid wages of $50.00 or more, or you can earn four credits for any year in which you have $400.00 or more in self-employed income. Work done anytime after 1936 can be counted if covered by the Social Security Law.

Many of us earned credits, when employed after 1936, before we became physicians. Those in the Armed Forces of the United States between September 16, 1940, and December 31, 1956, may be eligible for wage credits. Many have been employed during their professional lives and have been earning credits regularly. The number of credits needed to be insured for at least the minimum retirement benefits depends upon one's age, as the following shows:

Year of 65th birthday	Quarters of coverage needed
1960	9
1965	14
1970	19
1975	24
1980	29
1985	34
1991 or later	40

Under certain circumstances, benefits can be received with fewer quarters than shown in this chart.

The present law sets the percentage tax rate at a maximum of 7.8% (a tax of $514.80) on a base of $6,600.00 by 1987 for self-employed persons. Providing the tax rate stays the same (chances are it will eventually be increased to cover the increased benefits to be provided) and you earn at least $6,600.00 a year, you will pay into the system by the time you are

(Over)

65 years old, the following:

Age now	Amount contributed
40	$12,244.00
45	9,609.00
50	7,135.00
55	4,620.00
60	2,178.00

Your monthly retirement benefit will be determined by a formula involving your age at retirement, year of birth, number of years worked, amount earned, etc. An average check for a physician and his wife (retiring at age 65 and with less than $1,500.00 yearly earned income) would be $240.00/mo. In five years you could receive $14,400.00 in benefits.

I suggest you write the Social Security Administration, Baltimore, Maryland, 21235, and request a statement of earnings recorded to your own social security account. You can learn how many quarters (credits) you need to receive minimum benefits and how many you have already earned.

Like it or not, whether you will ever benefit or not, it is "the law of the land" and you are included in the Social Security Insurance Program beginning January 1, 1966. This should be sufficient reason for you to re-examine your present retirement and insurance programs.

Henry Burkhardt, M.D.

ACADEMY

The next meeting of the

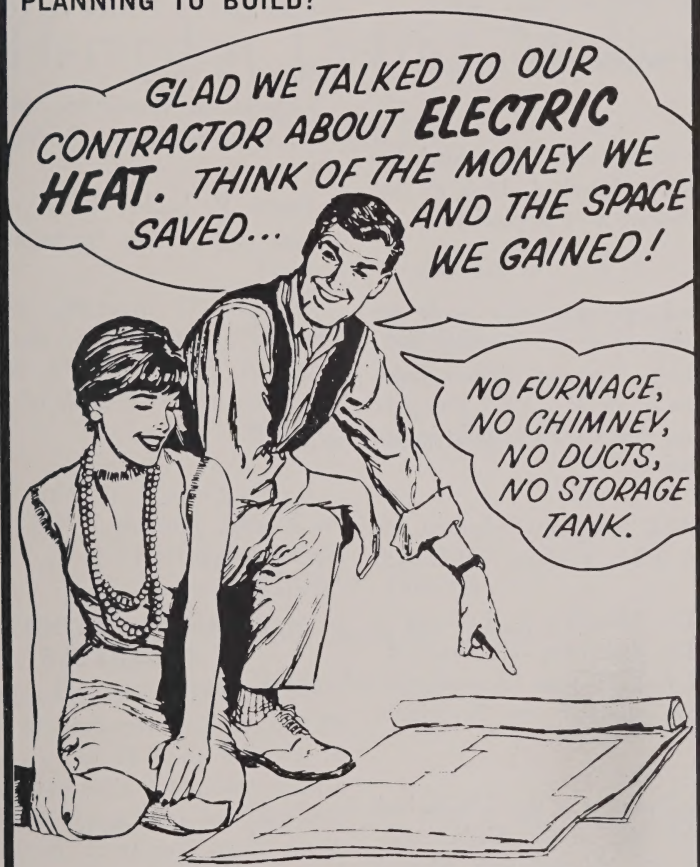
SPRINGFIELD ACADEMY OF MEDICINE

will be held on

TUESDAY, FEBRUARY 8, 8:30 P.M.

Speaker:	**EARL K. SHIREY, M.D.** **Cardiovascular Division** **Cleveland Clinic Foundation**
Topic:	**"CINE ARTERIOGRAPHY in the EVALUATION and SELECTION of SURGICAL PROCEDURES for CORONARY ARTERY DISEASE."**
Place:	**Auditorium, Municipal Hospital** **Springfield**
Hospital Clinic:	**Springfield Hospital, 5 P.M.**

PLANNING TO BUILD?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HAMPDEN CAPSULES

Dr. Kenneth Collard talked to nurses at Mary Lane Hospital on "The Medical Examiner System and the Nurses' Responsibility in Medical Legal Cases."

— —

On Radio WACE, Dr. Kinsella on Cytology.

— —

Please, try to pay your Mass. Med. Society dues before March 1, 1966 so that Hampden District will appreciate a rebate.

— —

Several bookings have been made for January for the use of the new film owned by H.D.M.S., "Quarter Million Teenagers." If you know of a PTA group or church group that is interested, please contact the office.

— —

Radio WACE programs planned for January, 1-2 P.M., Fridays - H.D.M.S. Day.

Jan. 7 - Dr. Orlansky on Epilepsy
Jan. 14 - Dr. Zadworny on Obstetrics
Jan. 21 - Dr. Keitlen on Gynecology
Jan. 28 - Dr. Larson on Psychiatric Treatments

— —

Dr. Appel, President of the A.M.A. had a "red carpet" tour of the Medical Department of the Massachusetts Mutual Life Insurance Company on Wednesday morning after his talk to H.D.M.S. Dr. Wales, Dr. Moore and Dr. Nay acted as hosts to this visit.

— —

Dr. Paul McCleave, Director of the Medicine and Religion Department of the A.M.A. will meet with our own Medico-Religious Committee at 10 A.M., on Feb. 2, 1966, at the Society offices at 1414 State Street. It is hoped that all of the committee will be able to attend.

Dr. Richard Butler of Wilbraham left H.D.M.S. for the sunny south - Georgia.

— —

Dr. Keitlen spoke to the Springfield College girls on "Sex and the College Girl."

— —

Removal of offices:

Donald G. Wetherbee, M.D., to 24 Fort Pleasant Ave., Springfield.

— —

Bruce B. Stoler, M.D. to 75 Van Deene Ave., West Springfield.

— —

"Anesthesia Mortality in Private Practice" is the title of an article by Harry N. Memery, M.D., Springfield, published in the JAMA of December 13, 1965.

— —

A Pre-Council meeting was held on Friday, January 7, 5 P.M. at Society headquarters.

DIABETES DETECTION COMMITTEE

Of the 13,000 Dreypaks distributed, 3500 have been returned to the H.D.M.S. office and 146 had a positive reaction. All tests to date have been completed by the laboratory Assistant students from Technical Institute. Last week some of our lovely ladies from the Woman's Auxiliary worked and all mailing has gone out to date to both patients and doctors, if there was a positive reaction. It is hoped that all physicians notified will please cooperate and send their replies as soon as possible to the H.D.M.S. office so our statistics can be completed and returned to the American Diabetes Association.

Louis A. Izenstein, M.D.
Chairman

NEXT MEETING
of the
Hampden District Medical Society

TIME: Tuesday, February 1, 1966

Business Meeting 6:30 P.M., followed by Social Hour.

Dinner (Courtesy of Society)

PLACE: Kimball Towers
140 Chestnut Street
Springfield

GUEST SPEAKER: REV. DR. PAUL B. McCLEAVE,
Director
Department of Medicine and
Religion, A.M.A.

YOUR PRESENCE IS URGENTLY REQUESTED

Harry N. Memery,
Secretary

Drug Abuse Control Amendments of 1965

On July 15, 1965, the 89th Congress passed The Drug Abuse Control Amendments of 1965 and this was signed into law by President Johnson, to become effective February 1, 1966.

Physicians in general have been aware of the need for such a law. The mounting rise of suicides, automobile accidents and criminal acts have in many instances been directly attributed to the use of barbiturates, amphetamines and tranquilizing drugs.

The seriousness of this problem was pointed out by Commissioner George P. Larrick of the U. S. Food and Drug Administration who states that nearly ten billion capsules and tablets of barbiturates and amphetamines are produced each year by pharmaceutical industries, and that half of these — five billion — are being diverted into unauthorized channels. Established figures further show 50% of college students by their second year, have been exposed to and take amphetamines.

Among the chief side effects of these drugs have been overstimulation and production of impaired and faulty judgment.

This new legislation will require registration of manufacturers and maintenance of accurate inventory records by the wholesaler, distributor and pharmacist. This, we hope, will curb, if not prevent, the enormous counterfeiting and illegal traffic of these drugs now in existence.

What is our responsibility as physicians? It is important that: (1) Prescriptions for amphetamines, barbiturates, or compounds thereof, bear the name and address of the patient and the date of issue; (2) we keep accurate records of our inventory and of prescriptions for at least three years; and (3) prescriptions not be made refillable for more than five times, or six months, whichever occurs first.

I might mention in passing that the phrase pro-re-nata (p.r.n.) on a prescription has no legal standing in the courts of the U. S. Attested judgments in courts have established ninety days as a reasonable period for refillability of any prescription.

Let us then, as physicians, stand 100% behind the HR2 Drug Abuse Control Amendments of 1965.

Zacarian

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COMING EVENTS

HAMPDEN DISTRICT MEETING, FEBRUARY 1 (PAGE 9).

EXECUTIVE COMMITTEE MEETINGS, FEBRUARY 15 AND MARCH 15.

ACADEMY OF MEDICINE, FEBRUARY 8 AND MARCH 8.

M.M.S. COUNCIL MEETING, FEBRUARY 9 AND MAY 16.

AMERICAN ACADEMY OF GENERAL PRACTICE, BOSTON, APRIL 1-7.

AMERICAN COLLEGE OF PHYSICIANS, NEW YORK, APRIL 18-22.

M.M.S. ANNUAL MEETING, BOSTON, MAY 16-18.

A.M.A. ANNUAL MEETING, CHICAGO, JUNE 26-30.

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MENTAL HEALTH COMMITTEE REPORT

As Chairman of the Hampden District Mental Health Committee and Vice President of the Executive Board of the proposed Mental Health Center for Springfield, I would like to submit a Progress Report to the Medical Society on the Mental Health Center.

Other physicians on the Board include Doctors Malcolm Allan, John Ayres, Joseph Baldwin, Michael Green, Robert Harrington, Ralph Miller, Thomas Reilly, and James Smith. Since its initial meeting in September of 1964, the Board has had regular meetings, by-laws have been drawn up, and officers elected. A Medical Advisory Committee has been formed under the chairmanship of Doctor Robert Harrington, and including in its membership, Doctors Burns Amberson, Joseph Bernstein, Olive Cooper, William Davis, Harry Goodman, Michael Green, John Griffin, Richard Maher, Theodore Miner, John Sandt and Robert Sears. This Medical Advisory Committee has had several meetings and at the present time, is drawing up a detailed Medical Program for the Center.

At the present time, a sub-committee of the Board is in the process of negotiating with the Board of Trustees of the Springfield Hospital in cooperation with the Department of Mental Health concerning the location of the Mental Health Center on the grounds of that hospital. The problems to be solved are still very great, but the members of the Board are optimistic that they can be solved to the satisfaction of all parties involved.

Since the Hampden District Medical Society has already expressed itself as being in favor of such a Mental Health Center in Springfield, I do not feel that any further resolutions are necessary from the Society at the present time.

Eugene G. Boss, Jr., M.D.
Chairman

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THE "HIPPOCRAT"
INTERVIEWS DR. APPEL
(December 7, 1965)

Q. Dr. Appel, does the A.M.A. intend to fight for modification of "Medicare"?

A. Yes, definitely! There are certain aspects already identified for modification such as the requirement of 3 days in an acute-care hospital prior to admission to an extended-care facility, such as a nursing home.

Q. Does the A.M.A. intend to fight for the repeal of "Medicare"?

A. Yes, if feasible. However, I refer only to title, XVIII (Title XIX, which refers to extended benefits under Kerr-Mills, as you know, we favor).

Q. Do you see any possible conflict between "Medicare" and our Code of Ethics?

A. Not at present. It all depends upon the nature of the rules and regulations adopted to administer "Medicare".

Q. Do you believe that "Medicare" will overtax our hospitals and other diagnostic and therapeutic facilities?

A. Yes, quite severely in sections of the nation. Less so in others depending upon the degree the communities have already enhanced hospital facilities. There will be tremendous overtaxing in extended care facilities all over the nation.

Q. Is the "American Association of Physicians and Surgeons" worthy of our support?

A. This is a militant rightist group in American medicine. Each doctor must make up his own mind if this organization suits his philosophy.

CORRESPONDENCE

MEDICARE and ETHICS

Dear Hippocrat:

Your December editorial entitled *Medicine and Medical Ethics* deserves comment.

The editorial quite properly raises trenchant questions regarding professional confidences and potential "certification pressures" which may arise under Medicare. The problem of "certification pressures", of course, does not owe its historical origin in the United States to the advent of Medicare. . . . These pressures can be dealt with effectively only by the counter-pressure of the professional probity of the individual physician. Medicare is no different in this respect.

The editorial states: "Medicare, in the opinion of many, threatens to undermine medicine. This being the case we have no right ethically to participate in its program." Sequentially it is unwarranted to jump abruptly from the phrase "in the opinion of many" in the first sentence with its implication of multitude to the word "we" in the second sentence with its implication of unanimity. If "many" feel that Medicare is unethical, then "many" are morally obliged to have nothing whatsoever to do with the program and indeed should reject the program with loathing. But in accord with the same logic, those who do not so believe, or those who despise serious doubts are prepared to follow the temperate recommendations of the American Medical Association and cooperate with the program have every right *ethically* to participate. To assert otherwise on the grounds of the alleged ultimate consequences of Medicare inaccurately brands the overall majority of physicians who will cooperate as unethical. . . .

The last sentence of the editorial, I am certain, cannot really mean what it says, to wit: "For it goes without saying that codes of law always take precedence over any and all codes of ethics." Without significant qualification, this is a dangerous doctrine to promulgate. Codes of law most assuredly do NOT take precedence over any and all codes of ethics, as any Protestant, Catholic, or Jewish clergyman can testify. It is a religious imperative that the moral man must always resolutely refuse to obey patently immoral laws. . . .

Lowell Bellin, M.D.

(Editor's Note:

The A.M.A. attaches no qualifications to the principle of law obedience. Section 4 of the Principles of Medical Ethics reads:

"The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. *Physicians should observe all laws**, uphold the dignity and honor of the profession and accept its selfimposed disciplines. *They should expose, without hesitation, illegal or unethical conduct* of fellow members of the profession."

* Italics are ours.)

Dr. Buck Calls Attention

Dear Hippocrat:

I believe I should call your attention to the fact that the National Congress on Medical Ethics and Professionalism, originally scheduled for October 2-3, 1965 in Chicago, as announced on page 10 of the December *Hippocrat,*

(Continued on Page 31)

CHRISTMAS MEMBERSHIP TEA

On Tuesday, December 7th, Mrs. Stephen A. Mahoney, II, opened her home at 201 Madison Avenue, Holyoke, at 2:00 p.m. for the annual Christmas membership tea of the Auxiliary.

The following new members who have joined the Auxiliary during the past year were guests of honor:

From Springfield - Mrs. Raymond L. Gagnon; Mrs. Ralph A. Williams.

From Longmeadow - Mrs. Jack H. Pincus; Mrs. James F. Nichols; Mrs. Terry Ryan; Mrs. Nathan Coleman; Mrs. Walton E. Stevens; Mrs. Robert Mendell; Mrs. Carl W. Janovsky.

From West Springfield - Mrs. Dalton L. Kinsella, Jr.

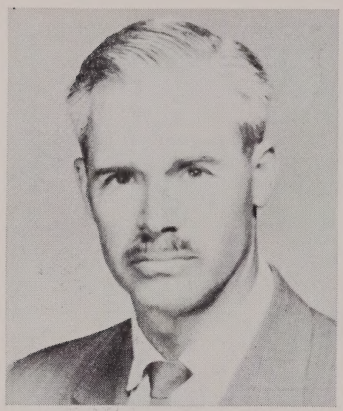
From Holyoke - Mrs. Victor Panitch.

Other guests were the wives of doctors from foreign countries who are affiliated with Hampden District hospitals. Over forty invitations were sent out by Mrs. Gardner Cox, II, who is chairman of the International Health Service Committee. She was assisted by Mrs. Charles D'Avanzo, state chairman.

Mrs. Raymond Conway, president, was honorary chairman of this Holiday event. Mrs. George Ross was general chairman and Mrs. Adolph Franz, Jr. co-chairman.

Mrs. F. M. H. Ziter
Publicity to the Hippocrat

WELCOME . . . . .



STEPHEN L. DALY, M.D.

Office: 111 Park Avenue, West Springfield

Born: Pelham Manor, N. Y., Feb. 3, 1917

Medical School:

New York University College of Medicine, 1943

Internship:

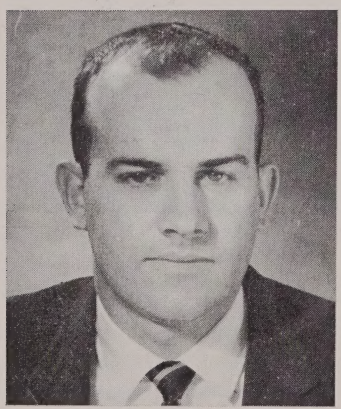
St. Vincent's Hospital, New York, N. Y.

Residency:

St. Vincent's, N. Y., Bellevue Hospital, N. Y., Institute of Living, Hartford, Conn., Conn. Valley Hospital, Middletown, Conn.

Specialty:

Psychiatry



WILLIAM J. DEAN, JR., M.D.

Office: 179 Walnut St., Holyoke

Residence: 35 Kane Road, Holyoke

Born: Holyoke, Mass., May 7, 1933

Medical School:

New York Medical College, 1964

Internship:

Springfield Hospital, Springfield

Specialty:

General Practice

SHELDON S. GOLDBERG, M.D.

Office: 120 Maple St., Springfield

Born: Springfield, Mass., August 19, 1928

Medical School:

Tufts University School of Medicine, 1960

Internship:

St. Joseph's, Syracuse, N. Y.

Residency:

Temple University, Philadelphia, Pa.

Specialty:

Otorhinolaryngology and bronchoesophagology

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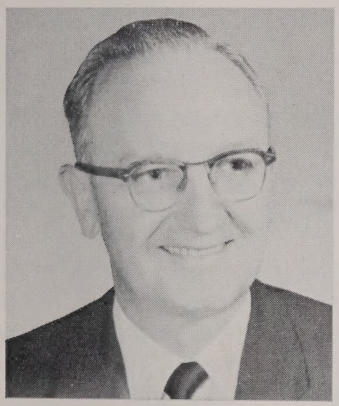


VICTOR GROVER, M.D.
Office: Springfield Hospital
Born: London, England, January 19, 1910

Medical School:
College of Physicians & Surgeons, Columbia University, N. Y., 1934

Internship:
Brooklyn Hospital, Brooklyn, N. Y.

Residency:
St. Luke's Hospital, New York, N. Y.

Specialty:
Internal Medicine

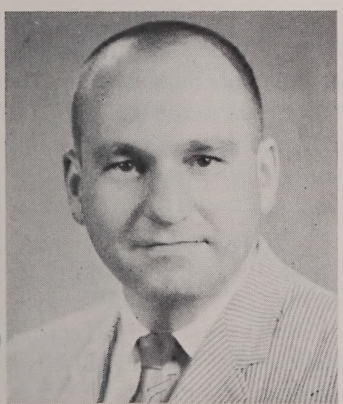
AARON M. LEAVITT, M.D.
Office: 52 Mulberry St., Springfield
Born: Springfield, Mass., November 25, 1930

Medical School:
The Chicago Medical School, Chicago, Ill., 1959

Internship:
Springfield Hospital, Springfield

Residency:
The Institute of Living, Hartford, Conn., Austen Riggs Center, Stockbridge, Mass.

Specialty:
Psychiatry



ROBERT S. MANDELL, M.D.
Office: 39 Mulberry St., Springfield
Born: Philadelphia, Pa., August 11, 1931

Medical School:
Hahnemann Medical College, Philadelphia, Pa., 1957

Internship:
Einstein Medical Center, Southern Division, Philadelphia, Pa.

Residency:
U. S. Veterans Administration Hospital, Philadelphia, Pa.

Specialty:
Urology

(OVER)

MARTIN J. POPPO, M.D.
Office: 130 Maple St., Springfield
Born: Rhinebeck, N. Y., October 24, 1935

Medical School:
McGill University,
Montreal, Quebec, Canada, 1961

Internship:
University of Illinois Research & Educational Hospital, Chicago, Ill.

Residency:
Clevelend Clinic, Cleveland, Ohio

Specialty:
Internal Medicine

MEETING FOR DOCTORS AND GRADUATE NURSES

Doctors and graduate nurses are invited to the twelfth annual joint Sectional Meeting of the American College of Surgeons in Cleveland, March 14-17, 1966. Headquarters hotel for doctors is the Sheraton-Cleveland, and for nurses the Statler Hilton. This is the College's only four-day meeting in 1966, and the only meeting with a program for nurses. This joint meeting pioneered in Cleveland in 1955.

Scope of the meeting approaches that of the annual Clinical Congress. In addition to sessions in general surgery there will be programs in the specialties of gynecology-obstetrics, neurosurgery, ophthalmology, otorhinolaryngology, orthopedics, plastic surgery, proctology, thoracic, urology and trauma. Approximately 50 industrial exhibits will be displayed.

Nurses sessions will include discussions on surgical and nursing management of cerebral aneurysm, trends in cardiac surgery, innovations in surgical specialties, training and utilization of non-professional personnel in the operating room, and the role of the professional nurse in the operating room.

THE NEXT

ISSUE
(February)

of the

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Please Remember to Save the February Issue of The "HIPPOCRAT".

Erratum

The title of the editorial on Page 3 of the December issue of the "Hippocrat" should have read *Medicare* and *Medical Ethics* instead of *Medicine* and *Medical Ethics.*

DR. APPEL'S ADDRESS

(Continued from Page 2)

News", a Canadian official was quoted as estimating that within five years 95 per cent of the Canadian population would be covered by medicare, a program which began as a hospitalization program only. Recently, Sen. Russell Long, the "majority whip" of the U.S. Senate, said he expects Social Security to be extended to include hospital care for disabled people below age 60 and to widows who cannot find work and who have children to support. And we shall not forget Mr. Forand's statement of several years ago: "If we can only get our foot in the door, we can go on from there." The door is open, but we must see that the chain lock is securely fastened so that the door is not opened wider and wider.

Despite what you may have heard or read, the position of the A.M.A. on "Medicare" is still a firm one. We have not urged our members to give in or surrender to "Medicare." We believe just as strongly as ever that these "Medicare" proposals, parts A and B (under Title XVIII) are not in the best interest of the United States.

Cooperation, Not Sabotage

Under "Medicare", the quality of the care to be provided for those over 65 is in serious danger because of the probable impact of this law on physicians, hospitals, nursing homes and other institutional and individual vendors of health care. However, your A.M.A. believes that the only statesmanlike and rational behavior is to try, in the most effective way possible, to bring about regulations and other implementations that will mitigate the damaging effects that we know are likely to occur. Your A.M.A. feels that its efforts now must be directed toward preserving and strengthening to the fullest degree possible the freedom of physicians, hospitals, and other personnel involved in the rendition of the benefits provided. At the same time we shall exercise our fight to criticize the "Law," any of its sections or regulations, and to urge amendment or repeal when such actions are indicated. And, when and if our continuous studies of the "Law" and its regulations indicate it advisable, we are prepared to test their constitutionality in the courts of law.

If this is our intent, then, indeed, we must be responsible, we must be objective, and we must be discretionary in all our responses to the development of administrative policies and the actual implementation of the "Law." The people of this nation know the

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"Law" cannot be implemented without the use of the medical profession. Sabotage by non-cooperation will not develop and demonstrate the harmful effects that need correction by amendment or even, perhaps, repeal. Such non-cooperation will only bring down upon the medical profession the flames of vituperation from the public, fanned by the social planners who promoted this bill in full knowledge of its imperfections and only as a step towards a more radical departure from a free society. Consequently, an advisory committee of the A.M.A. has been meeting with HEW officials to give advice and guidance in the implementation of "Medicare" regulations. Otherwise, hastily written and unrealistic regulations could aggravate even further the undesirable effect of the "Law."

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Free Choice of Physician

While I do not have time to cover all the ways in which Public Law 89-97 will affect you, let's take a brief look at a few of them. First, of course, is the matter of physician-patient relationship under "Medicare," or what has come to be known as participation versus non-participation. Your A.M.A. does not believe that any individual physician should be dictated to regarding his choice of rendering care to patients under the conditions embodied in, or to be written into, Public Law 89-97.

Your A.M.A. House of Delegates said this emphatically when it adopted a resolution which states that the A.M.A. will oppose "any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97." On the other hand, the medical profession subscribes to a set of principles which point out that under certain circumstances we cannot refuse our services to our patients. In essence, these circumstances occur when refusal to serve would deprive a patient of needed medical care. "Medicare" is the "Law." We must obey the "Law." The "Law" specifically states it is not compulsory for physicians to render serv-

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ices under its provisions. But no one should suffer for inability to secure needed medical service. Thus, each physician must make his own decision as to the course he will pursue, and the "Law" clearly permits this. So the effect "Medicare" will have on your practice depends largely on your decision to participate or not to participate.

Billing and Payment for Services

Another effect of the law on your practice relates to billing and payment for services. This matter was the subject of much debate in the recent Clinical Convention of the House of Delegates. As you know, the "Law" provides:

1. That all professional services shall be financed in accordance with the provisions contained in Part B of Title XVIII.
2. That physicians can be paid their fees in accordance with two distinctive methods:
   a. Directly billing and collecting from the patient the physician's usual fee, furnishing the patient a receipted bill which the patient then would present to the carrier with a comp'eted claim form and, if claim is eligible, the carrier would reimburse the patient in accordance with its fee schedules and to an amount permissible under the contract (80% of the remainder at the carrier's fee schedule allowance after deduction of the initial $50 if such $50 had not already been paid during the year);
   b. Or by signing by the physician

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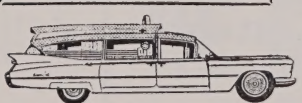

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and the patient jointly an assignment to the former which, with the claim form and the assurance that the $50 deductible had been paid, would be forwarded to the carrier; (In this case, the claim cannot exceed the fee schedule of the carrier. The physician would be paid directly by the carrier and would accept this amount plus the 20% co-insurance and the $50 deductible, if applicable, as full payment for his services.)

3. That charges made by physicians shall be reasonable, usual, and customary. The "Law" does not precisely define these terms. Rules, regulations must be developed to do this. One definition is that the fees charged shall be the same that the physician charges for similar services provided to other patients he treats, and such fees must likewise relate to fees charged by other physicians in the same area for similar services. The NABSP (National Association of Blue Shield Plans) has been developing the prevailing fee concept. This concept is based on physicians in a given area furnishing the carrier with a list of their usual fees charged. A physician fee profile would thus be developed for the area, and the carrier would thereafter pay the full fees of each physician in the area whose fees fall within the first 90th percentile. The benefits paid would of course be subject to the $50 deductible and the 20% co-insurance factors. Physicians whose fees fell above the 90th percentile (the top 10% bracket) would not be paid directly. The benefits provided by the carrier would be paid directly to the patient. The physician would then depend entirely on receiving his fee directly from the patient. Moreover, physicians could not effect increases in their fee schedule without giving 90 days prior notice to the carrier.

Professional Fees vs. Hospital Charges

Now let us consider the separation of professional fees and hospital charges in depth. As you know, in the "Law", the hospital-based specialists and their services are under Part B, Supplementary Medical Insurance Benefits for the Aged. Only actual hospital costs related to these types of

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services will be billed as hospital services under Part A. However, Senator Douglas of Illinois has proposed an amendment which would define the hospital-based specialists' services of 25,000 practicing radiologists, pathologists, anesthesiologists, and physiatrists as "in-patient hospital services". Thus, by federal law, hospitals would be authorized to sell the services of these physicians as a hospital service. During the October, 1965, special session, the House of Delegates made this clear and succinct statement on this issue. "Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be *established, billed,* and *collected* by the medical specialist in the same manner as are the fees of other physicians." At the Clinical Convention held in Philadelphia during the latter part of November, 1965, the House approved a resolution calling for continued efforts through "all appropriate channels" to achieve a separation of billing and payment for professional fees from hospital charges under contracts written by the health insurance industry.

Since its organization, the A.M.A. Advisory Committee to HEW and its representatives on the technical advisory committees appointed by Secretary Gardner to assist in the development of the rules and regulations necessary to implement the "Law" have been working to activate those principles in the implementation of Public Law 89-97. This can best be accomplished by working out an agreement with the AHA on the technique to be used in the separation of the professional component of services rendered and the procedures carried out under the direction and supervision of the physician-specialist from the technical component of these services and procedures which should be billed by the hospital under Part A of the "Law". Representatives of these specialist groups have been meeting with the AHA in an effort to accomplish such an agreement. It is my understanding that this does not present as

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much of a problem for the radiologists and anesthesiologists as it does for the pathologists and physiatrists. However, rest assured that your A.M.A. stands ready to assist these specialty groups in accomplishing a satisfactory agreement whenever any of these groups seek such assistance. It is, however, the sincere hope of the A.M.A. that the resolution of this problem of separation of professional services from technical services will not result in an overall increase in costs of these services to the patients as compared with present charges.

Direct Billing vs. Assignment

In an effort to better identify the merits and demerits of the two systems of billing provided by the "Law" - i.e., direct billing the patient vs. using the assignment technique,-the A.M.A. House of Delegates has adopted eight statements on billing and payment for medical services. These are applicable "irrespective of whether such fees are paid by the patient or paid or reimbursed in whole or in part under Public Law 89-97 or any other third party plan." Here are the eight statements:

1. "The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.
2. "It is the patient's responsibility to deal with third party carriers in the area of financial assistance provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.
3. "The physician-patient relationship is served best when there is an advance understanding regarding the payment of fees and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.
4. "The A.M.A. does not approve of any program which may directly or

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indirectly promote the charging of excessive fees or which interfere with the physician's right to charge fees commensurate with the services he renders.

5. "The A.M.A. opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.
6. "It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also, any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the professional. The foregoing is from a report of the Council on Medical Service to the House of Delegates at the Clinical Meeting in 1954).
7. "The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. (The foregoing is from a report of the Judicial Council which was approved by the House of Delegates at the Clinical Meeting in 1960).
8. "It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his

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particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession. (The foregoing is from an opinion of the Judicial Council in 1958)."

"Usual and Customary" vs. "Prevailing" Fees

The two concepts - "usual and customary" versus "prevailing" fees - provoked one of the most controversial issues before the House of Delegates. The House reaffirmed its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in government programs at all levels of government. It also urged "the individual physician's 'usual and customary' fee concept to all third parties." It took this action after modifying a Board of Trustees' report on the new "prevailing fees" program of NABSP. The modified report recommended: "That the concept of the prevailing fees program of the NABSP be noted as one of the methods of compensation to those regions where the prevailing fees program is approved by the local or state medical society."

In its report, the Board of Trustees recalled a statement adopted by the House at the 1965 Annual Convention, which recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. "Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of 'usual and customary' fees."

Utilization Review Committees

Another area of vital concern is the matter of utilization review committees in hospitals. As you know, there has been a great deal of discussion, with a variety of opinions, as to the purpose of such committees, but there has been general agreement that membership be

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limited to include physicians only. Consequently, at its special session, your House adopted a statement declaring that "hospital utilization review committees shall be composed of practicing physicians." To my mind, the autonomy of the medical staff of a hospital must be preserved if we wish our patients to receive the kind of care they deserve. The determination of need for or extent of health care in a hospital cannot be made by people not knowledgeable in medicine. So, the medical staff of the hospital must accept this responsibility. It cannot permit lay people, administrators or social workers to dictate to the staff on these matters. I believe that we shall need to set up good lines of communication and cooperation with utilization committees. If we do not, I am certain that we could wind up with "outside appointments to utilization committees - and I definitely mean "non-medical" appointments.

If the membership of utilization committees indeed are limited to physicians, then a group of second concerns crop up, such as the function of the committees and the cooperation with them by physicians. I personally believe that the utilization committee should be more of an auditing committee than a punitive body. I would be remiss if I did not specifically point out the role of the utilization committee in the "Medicare Law." This role is not one that would lead to refusal of hospital admission nor decree early discharge of a patient from the hospital. Under "Medicare", the decisions of the utilization committee would merely determine if benefits may be paid and when such payments should terminate. Along this line of thinking, the House of Delegates at the Clinical Convention declared that the A.M.A. Advisory Committee on Public Law 89-97 and 89-239 should persist in its efforts to achieve "practical recognition" by HEW of the differences between utilization review and claims review. The House adopted a report of the Council on Medical Service which said that "widespread confusion exists between the utilization review function and the claims review function." It also received a series of recommendations in the report aimed at clearing the confusion.

Joint Responsibility

When we look objectively at the total problem, we can only conclude that health care is the joint responsibility of governmental health agencies and private practicing physicians. When either one tries to do it alone or to dominate, quality of care suffers.

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I would not be talking with the federal government in Washington if I did not thoroughly believe this. I have found in Washington a cordial reception, an attentive ear, and a willingness to cooperate and accept ideas and proposals especially when such ideas and proposals are obviously sound and in the best interests of the people whose health both the federal government and the medical profession want to protect.

I became particularly grateful when during the Clinical Convention of the House of Delegates I received support for these observations. A meeting was held by the A.M.A. Advisory Committee with the A.M.A. nominees serving on the technical advisory committees of HEW referred to previously. This meeting was open to all members of the A.M.A. and others. Each member of the technical committees reported on his work on the technical committees and his impressions of the entire process. Subsequent to this meeting on the floor of the House of Delegates, Dr. Edward Annis, Past-President of the A.M.A. and consultant to the A.M.A. Advisory Committee moved that the House of Delegates commend Mr. Arthus Hess, the director of the Social Security's Bureau of Health Insurance, for his "whole hearted cooperation" with the A.M.A.'s advisory and technical committees on "Medicare." This motion was adopted unanimously, with applause and without debate. All these, then are some of the ways in which "Medicare" will affect you and your practice. I suspect that many other questions will arise and many problems will present themselves as this new law moves closer to the active stage.

Nevertheless, I do think that this particular period we are all going through must be a time of restraint and prudence. I don't believe that irresponsible anger and frustration will bring us any kind of success.

"Eternal Vigilance"

Finally, even though one small section of the "city" has been occupied, we must remember that our task now is to preserve the remainder of the "city" and to double and redouble our efforts to see that the remaining private sector of medicine is not invaded by the federal government. Let's remember that last year 151,123,000 Americans, or 70% of the population, voluntarily purchased health insurance. This represents a substantial investment by many families to buy care in case of need and certainly must be interpreted as an overwhelming vote of public confidence in the system. I submit to you that the effects of the

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"Medicare" law on you and your practice are important. I also submit to you that the effects of expansion of the "Law" and further government intervention and control are even more important to you and your practice.

While not exactly germane to the main subject we are now discussing, I would feel remiss if I failed to report on some thoughts Dr. F. J. L. Blasingame brought to the House of Delegates in Philadelphia. These thoughts were embodied in his most informative address outlining the program, facilities, and activities of the A.M.A. Headquarters and the services given by the A.M.A. through its various councils and committees to the profession and the public. Dr. Blasingame warned the House that it appeared as if the federal government, the university medical school complex, and the hospital system is combining "to mold and shape the patterns of health care in this country." He said that this "triumvirate of forces has enormous potential for drastically altering the pattern of medical education, research, and service." He also urged the medical profession to be "prepared to seize the initiative and keep it" on the vital issues of medical education, rising health care costs, quality controls, ethics, and discipline and to strengthen the medical federation at the state and local levels.

To this I can only say "Amen." Thus we cannot "throw in the sponge" and quit the struggle. We need your concern and your influence more than ever before. We need your vigilance. We need your strength. We need you for the unity of the health profession that these critical times demand. We need your keen desire for freedom in medicine. Without it, together, we shall fail in our stewardship to humanity. #

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MENTAL HEALTH HEARINGS ARE HELD

On December 13, 1965, a hearing on the findings and recommendations of the Task Forces on Mental Health was held at the auditorium of the Municipal Hospital, Springfield.

These Task Forces were set up in 1963 under a $175,000 grant from the federal government to study present-day mental health practices in Massachusetts and to make recommendations for possible improvement. Hearings on this report are being held also in Boston and Worcester by a panel from the Department of Mental Health and Lt. Governor Richardson, who will introduce legislation to implement recommendations. This will be necessary as mental health is the most legislated of all fields of medicine.

The report under consideration covered the fields of adult crime, juvenile delinquency, adult mentally ill, aging, alcoholism, communications, health education, drug addiction, emotionally disturbed children and adolescents, epilepsy, government structures and legislation, financing, manpower, mental retardation, occupational mental health, research, training, administratiion and community health programs. The Task Forces consisted of 300 people interested in mental health including our own Drs. Cooper, Donoghue, Larson and Osterheld. Copies of the report have just become available in Western Massachustts.

The report contains 170 recommendations. The ones most discussed related to community mental health centers. The report divided the state into six regions for which thirty-seven centers are planned. Springfield is 6th existing in order of priority which is measured by need or the lack of existing facilities.

Much of the testimony revolved about the mental health centers. A local center has been authorized by the state legislature. Negotiations between a local committee and the Department of Mental Health have been going on for the past year. The slowness in negotiations has been due to the insistance by the local committee on some form of local control as recommended by the study of 1962, as well as by the resolutions of the H.D.-M.S. and the local Community Council. The commissioner, on the other hand, is limited by law which requires all mental illness to be the responsibility of the State Department of Mental Health. All testimony at this hearing upheld the principle of local responsibility and agreed that some form of legislation that would permit it was necessary.

The proposal that the towns of Monson, Palmer and Ware be included in the Southbridge center were also opposed as they all belong in the area of the Hampden District Medical Society. It was pointed out by a member of the panel that two centers would ultimately be required in metropolitan Springfield since it covers a population of nearly 400,000 people.

Testifying at the hearing were representatives of the various local mental health clinics and social agencies related to mental health, the community council schools, H.D.M.S. and

COMPLIMENTS

Ernest A. Byron

SPRINGFIELD

DR. BUCK

(from Page 14)

w[illegible] cancelled because of the special session of the House of Delegates of the A.M.A., and has been rescheduled for Saturday and Sunday, March 5 and 6 at the Pick Congress Hotel in Chicago. It is not too late for any of your members to arrange their plans if they wish to attend.

I should further point out that the announcement by Dr. Hayes (December, page 19) that ". . . . it isn't necessary for the physician to sign the Civil Rights Oath as formerly reported", is not quite accurate, since it does not apply to Massachusetts physicians. I call your attention to an editorial in the December 23rd issue of the *New England Journal of Medicine* that I wrote after exhaustive correspondence and investigation of this situation. I assure you that it is accurate, and that only state legislation seems to o[illegible] any relief to our local doctors.

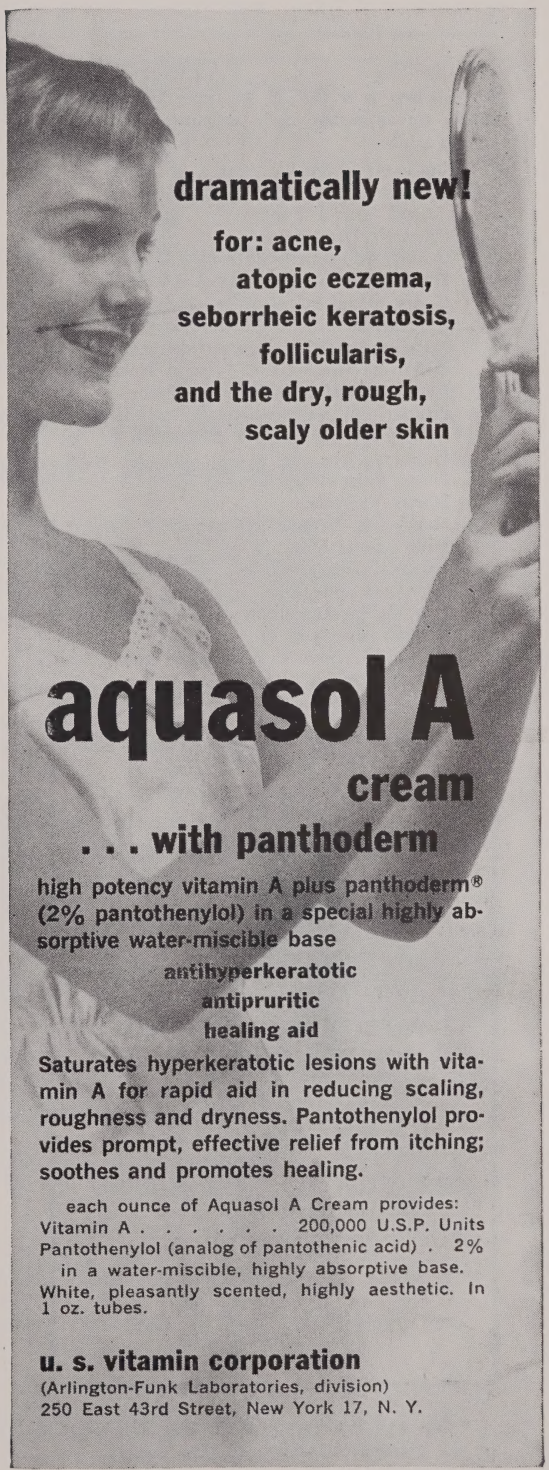
Robert W. Buck, M.D.
Secretary, M.M.S.

Absorbine Jr.

western Mass. Psychiatric Society. Dr. Lowell Bellin read a prepared statement of 24 pages, and a group from Berkshire County presented strong arguments for local autonomy.

The panel consisted of Lt. Governor Richardson representing the Legislative branch of the government, Doctor James Dykens, Mr. Harold Demone of the Department of Mental Health, and Mr. William Curran, [illegible] of Boston University Metro. C[illegible]ter and legal counsel for the panel.

Miller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The opinions expressed in The Hippocrat do not necessarily represent the official viewpoint of the Hampden District Medical Society.

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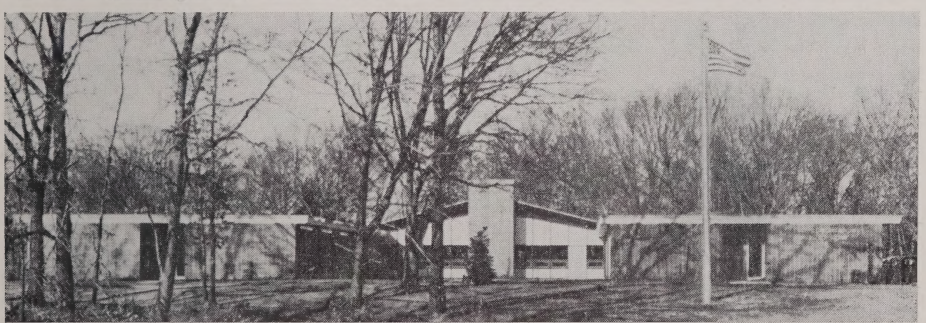

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